STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215299	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate Hills Rehab & Healthcare Ctr	10 North Rock Glen Road Baltimore, MD 21229

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews, it was determined that facility staff failed to ensure a resident was free from verbal abuse. This deficient practice was evident for one (#215) resident reviewed for abuse during the complaint survey.The findings include: On 10/08/25, a review of the Facility Reported Incident (FRI) # 2629130 revealed that on 09/26/25 at 1:30 PM, Resident #215 informed Social Service (SS) Director #2 that Geriatric Nursing Assistant (GNA)#17 was verbally aggressive towards them on 09/25/25 during the 3PM-11PM Shift. On 10/08/25, the surveyor requested the employee file for GNA #17. A review of employee file reviewed documentation of an interview conducted on 09/26/25 by the Administrator regarding the incident involving Resident #215 on 09/25/25. During the interview, the GNA stated she was tired of being labeled as the aggressive person. When the Administrator asked if anything occurred with her and Resident #215 on 09/25/25, the GNA confirmed that there had been an incident and stated that the resident had called her inappropriate names. The GNA informed the Administrator that she would not be returning to the facility and ended the call. A review of the investigation file revealed that the Administrator conducted an abuse questionnaire of staff on Unit One. The question asked was Have you witnessed any staff member verbally abuse any resident? All four staff members responded no. No additional or follow-up questions were documented to clarify details related to the incident. A review of an abuse questionnaire completed by SS #2 on 09/26/25, for resident's residing on Unit One revealed that residents were asked Have you seen any resident here being abuse? All residents responded, no except for Resident # 218 who answered, yes. Further review of the questionnaire form indicated that any yes response required the collection of additional and report immediately. There was no documentation showing that any follow-up information was obtained from Resident #218 after the yes response.On 10/08/2025 at 10:46 AM, during an interview with Resident #215 regarding the incident involving GNA #17, the resident who has a diagnosis of legally blind, reported that they rang the call bell for assistance to use the bathroom and waited over two hours before a staff member entered the room. The resident stated that they became upset about the delay and an argument between the resident and GNA #17 began. The resident further explained that during the argument, the GNA called the resident a blind curse word. The resident reported that they chose not to respond. When asked if there was a witness present, the resident confirmed that their roommate was present during the incident.On 10/08/25 at 10:58 AM, during an interview with SS #2, the surveyor asked if she recalled the incident that occurred between Resident #215 and GNA #17 on 09/95/25. The SS #2 stated that while interviewing Resident #215 regarding an unrelated matter, the resident reported an allegation of the verbal abuse. When asked if she was familiar with Resident #215 and Resident #218 and if either had a history of conflict with staff, SS#2 stated that both the resident and their roommate were not known to cause trouble or fabricate complaints. Another staff member was present during the interview and confirmed that neither resident had a history of issues with staff. On 10/08/2025 11:25 AM, during an interview with the DON and Administrator, the surveyor discussed the investigation file related to Resident #215 and noted the lack of staff, witnesses and alleged victim interviews. The surveyor asked the Administrator how she was able to reach an inconclusive finding without conducting and documenting pertinent interviews. The Administrator stated that interviews were conducted using questionnaire but acknowledged that the interviews were not documented. She further explained that two residents reported the verbal abuse, and two staff members denied the verbal abuse, therefore she was unable to verify the allegations. The surveyor requested evidence supporting the staff member statements that GNA #17 did not curse at Resident #215, the Administrator stated that she did not have any documents to support the statement.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that the facility failed to report an injury of unknown origin to the State Agency (SA) within the required time frame of discovering the incident, as required by regulation. This was evident for 1 out of 6 facility reported incidents during the complaint survey.The findings include:On 10/08/2025 at 8:20 AM, the surveyor reviewed the facility's investigation packet for intake #2605804, which revealed the facility reported an injury of unknown origin for Resident #203 on 09/02/2025. On 10/08/2025 8:23 AM, further review of the initial self-report sent to the State Agency (SA) revealed that the facility became aware of Resident #203's injury of unknown origin on 09/02/2025 at 7:20 AM and reported it to the state Agency (SA) on 09/02/2025 at 11:02 AM. The elapsed time between identification of the injury and the facility's report to the SA was approximately 3 hours and 42 minutes, exceeding the required two-hour reporting timeframe.On 10/08/2025 at 12:48 PM, during an interview with the Nursing Home Administrator (NHA), when asked when an allegation of an injury of unknown origin should be reported to the State Agency (SA), she stated the facility had a two-hour window period to report such incidents. When informed that the facility reported the incident nearly four hours after discovery, the NHA acknowledged awareness of the late reporting and stated she was implementing measures to prevent recurrence.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews, it was determined that facility staff failed to conduct a thorough investigation of alleged violations for residents. This deficient practice was evident for two (#205, #215) of sixteen residents reviewed for investigation of alleged violations during the complaint survey.The findings include:1.) On 10/07/25 at 8:07 AM, a review of the Facility Reported Incident (FRI) #2594457 revealed that the Administrator and Director of Nursing (DON) received an email on 08/14/25 from a complainant regarding care, nutrition, hydration, and hygiene concerns for Resident #205. Further review of the investigation file revealed that the email from the complainant was missing from the file. The surveyor requested to review the email sent to the Administrator and DON. On 10/07/25, the DON provided the surveyor with an email from the complainant. A review of the email revealed that the complainant expressed specific concerns that were not included in the initial FRI. The complaint involved issues related to the residents' medications, oxygen, food, water, personal care, cleanliness, and lack of medical care. The complainant provided a timeline of events that had taken place within 14 days of the email:08/01/25-Resident #205 was not changed for hours.08/03/25-Resident #205 did not receive water as needed.08/04/25-Resident #205 was not changed from the previous night, between 11:00 PM, on 08/03/25 and 4:00 PM on 08/04/25, the resident remained in soiled clothing and bodily fluids. 08/06/25-Resident #205, experienced multiple episodes of vomiting and had to wait an extended period before being cleaned by staff.Further review of the investigation file showed the facility's follow-up related to the reported allegations. The Administrator and DON conducted an interview with Resident #205 on 08/15/25 and the residents only expressed concern about a delay in receiving care after vomiting on 08/06/25. A staff member was interviewed and reported that on 08/04/25, the resident had refused incontinence care earlier that day. Based on the residents' history of refusing care and the facility's inability to verify the length of the delay in care, the Administrator concluded the allegation could not be substantiated. However, there was no evidence that the facility investigated the complainants' additional concerns regarding the residents' medication, oxygen, and overall care On 10/07/25 at 9:05 AM, the surveyor requested the documentation report and task records for Resident #205 related to incontinence care and hygiene care. On 10/07/25 at 9:18 AM, a review of a documentation report for Resident #205 for August 2025 revealed that toileting hygiene, bladder incontinent, and bowel incontinent care were documented as provided on 08/01/25 at 9:21 AM. The next entry for toileting hygiene, bladder incontinent, and bowel incontinent care was documented later that day at 10:11PM. Further review showed that on 08/04/25, these same care activities were documented at 2:18 AM, with the next entry documented at 2:59 PM. On 08/06/25 a review of personal hygiene revealed that care was provided at 6:25 PM, with the next entry documented on 08/07/24 at 1:14 AM. During an interview with the Administrator and DON on 10/07/25 at 12:30 PM, the surveyor discussed the incontinence care provided to Resident #205. Review of the documentation report indicated that on 08/01/25 and 08/04/25, the resident may have gone over 12 hours without being changed. The surveyor requested any paper or electronic records verifying that the resident received incontinence care more frequently than documented. Both the Administrator and DON stated that staff were interviewed and reported the resident had been changed, however, the facility was unable to provide documentation to confirm that the resident did not go for an extended period without incontinent care. On 10/08/25 at 8:06 AM, during an interview with the Administrator, when asked why all concerns expressed by the complainant via email were not addressed, the Administrator stated that during her interview with Resident #205 the resident did not report all the concerns mentioned in the email. The resident only expressed concern about the delay in being changed after vomiting on 08/06/25. No additional evidence was provided to show that oxygen or medication concerns mentioned in the complainants' email were investigated. 2.) On 10/08/25, a review of the FRI # 2629130 revealed that on 09/26/25 at 1:30 PM, Resident #215 informed Social Service (SS) Director #2 that Geriatric Nursing Assistant (GNA)#17 was verbally aggressive towards them on 09/25/25 during the 3PM-11PM Shift. Further review of the file indicated that an investigation was initiated.A review of the follow-up investigation report indicated that staff and resident interviews were documented as having been conducted, however, the investigation file failed to show evidence of these interviews other than the interview with the alleged perpetrator GNA #17.A review of the investigation file revealed that the Administrator conducted an abuse questionnaire with four staff members who worked on Unit One during the 3:00PM-11:00PM shift on 09/25/25. The question asked was Have you witnessed any staff member verbally abuse any resident? All four staff members responded no. No

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews and record reviews it was determined that facility staff failed to provide care to a resident who was dependent on staff for personal hygiene and incontinence care. This deficient practice was evident for 1 (#201) resident reviewed for ADL care during the complaint survey. The findings include:On 10/07/25 at 10:30 AM, a review of the Facility Reported Incident (FRI) # 2590945 revealed that the complainant alleged that Resident #201 and other residents were often left wet and soiled. During a phone interview with the complainant on 10/08/25 at 12:45 PM, they further explained that Resident #201 was observed unbathed and soiled with urine and bowel movement on their gown on 07/04/25 and 07/25/25. During an interview with Geriatric Nursing Assistant (GNA) #4 on 10/07/25 at 10:45 AM, the surveyor asked about the process for documenting resident's baths, showers, and personal hygiene. The GNA explained that GNA's are responsible for documenting on the computer whether the resident received a shower. She further stated that GNAs must also record the resident's shower or refusal in the unit's shower logbook. Additionally, the GNA also stated that if a resident refuses a shower or bed bath, the GNA must inform the resident's nurse. On 10/07/25 at 11:16 AM, during an interview with Assistant Director of Nursing (ADON)/Unit Manager, she explained that residents are assigned shower days, and staff are expected to provide showers on those designated days. Staff are required to document the completed or refusal of the shower in the resident's electronic medical record, as well as in the unit's shower logbook. The ADON further states that GNAs must report any shower refusals to the nurse. The nurse is expected to follow up with the resident and document the resident's refusal. A review of Resident #201's electronic medical records on 10/08/25 indicated that the resident was scheduled to receive showers on Tuesday and Saturdays during the 3:00 PM to 11:00 PM shift. Further review of the records failed to show a nursing note documenting the residents' refusal of shower or bed bath.On 10/08/25, the surveyor requested to review the shower logbooks for both units 1 & 2 for the month of July 2025. A review of both shower logs revealed that Resident #201 received a bed bath on 07/03/25, and 07/14/25. Based on the resident's shower schedule, there should have been nine shower logbook entries documented for the month of July, however, only two entries were recorded for the resident. On 10/08/25 at 12:59 PM, a review of documentation report for Resident #201 for July 2025 revealed that bladder incontinence and bowel incontinence care were documented as provided on 07/04/25 at 5:36 PM. The next entry was documented on 07/05/25 at 3:32 AM. Further review showed that on 07/25/25 these same care activities were documented at 12:33 AM, with the next entry documented at 2:21 PM. During an interview with the Administrator and DON on 10/08/25 at 1:30 PM, the surveyor discussed the shower logbook and incontinence care provided to Resident #201. The surveyor requested any paper or electronic documentation verifying that the resident received showers and incontinence care more frequently than documented. Both the Administrator and DON stated that the facility was unable to provide documentation to confirm that the resident did not go an extended period without receiving incontinent care and showers as ordered.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and staff interviews, it was determined that the facility failed to prevent an avoidable pressure injury. This was evident for 1 (Resident #208) out of 2 residents reviewed for pressure injuries. Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. The findings include. On 10/6/2025 at 9:39 AM, a review of Complaint #2616868 was completed. The complainant alleged that the facility was not treating and preventing pressure injuries for Resident #208. On 10/6/2025 at 9:54 AM, a review of Resident #208's records was conducted. In the Skin and Wound evaluation on 9/12/2025, Staff #6 documented, Right knee brace removed to assess entire skin when both wound [Nurse Practitioner] and writer noticed an indentation to right lateral knee noted as a traumatic wound [Related to] the brace. In the Skin and Wound note on 9/12/2025, the Wound Nurse Practitioner (Staff #16) provided the following recommendations: Check daily underneath brace to ensure there are no wounds. Recommend follow up with ortho regarding new Right lateral knee wound caused by knee brace, and see if there is a different brace [the resident] can wear that won't rub on this area, or if [the resident] can go without the brace now. Betadine wet to dry dressing to the wound, and extra padding to prevent trauma from brace. On 10/6/2025 at 10:59 AM, a review of Resident #208's Orders was conducted. An order for the patient to don R hinge-knee brace locked into extension at all times. No ROM allowed through R knee was placed on 8/4/2025 and discontinued on 9/16/2025. An order to assess the skin under the brace and report abnormalities was placed on 7/29/2025 and discontinued on 8/1/2025. On 10/6/2025 at 12:25 PM, An interview with Staff #9 and Staff #10 was conducted. When asked what is the standard for assessing resident's with braces or orthopedic devices. Nurses should assess the resident's skin before and after placement of device. When asked how often these skin checks are completed, they stated that they would assess the skin every 4 hour or as long as the order indicated. When asked what if the order stated to keep a device on at all times, the staff indicated that ideally the skin and resident would be assessed every 2 hours. When asked if there needed to be an order to complete a skin check under these devices, they stated that orders for assessment are usually placed but that it was an expectation that skin under the devices be checked regardless of being an order or not.On 10/6/2025 at 12:42 PM, a review of the resident's care plan was conducted. A care plan for skin impairment and wounds had an intervention to Please check right knee skin under immobilizer Q shift. Notify MD/NP for any abnormality. No documentation for intervention was found in progress notes or treatment administration record after 8/1/2025 and prior to 9/12/2025.On 10/06/2025 at 12:55 PM, the Director of Nursing was made aware of concern regarding Resident #208's pressure injury found under knee brace.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, interviews and observations, it was determined that the facility failed to ensure fall prevention interventions were in place to prevent future falls. This was evident for 1 (Resident #213) of 2 residents reviewed for falls during a complaint survey.The findings include: On 10/06/2025 at 8:03 AM A review of the complaint #328732 sent to the state agency was conducted. The complainant reported that the facility was not implementing interventions to prevent future falls for Resident #213.On 10/06/2025 at 9:47 AM An interview with the complainant was conducted. The complainant reported that Resident #213 had several falls in March 2025 and that not all fall prevention interventions were put in place.On 10/06/2025 at 10:21 AM Further review of the record indicated that the resident had several falls in March 2025. The Resident had a fall on 3/6/25, 3/7/25, 3/19/25 and 3/24/2025.Further review of the records indicated that the resident had been identified as a high risk for falls. The interventions documented on the care plan included frequent rounding on the resident, bilateral fall mats, and a call pad should be near reach, and to be placed on the bed on the side the resident frequently falls on.On 10/07/2025 at 9:07 AM During unit round, the surveyor observed Resident #213 lying on the right side of the bed. The call pad was not near reach and not on the resident's bed. The call pad was placed on top of a suctioning container that was on the bedside table. On 10/07/2025 at 1:35 PM Another observation was made by the surveyor. At this time, the call pad was also not on the resident's bed. During this observation, Resident #213's representative was at the bedside. The representative stated that they've observed the call pad not near reach. The resident representative showed the surveyor a picture that was taken on 10/4/2025, which showed the call pad on top of the oxygen humidifier machine. On 10/07/2025 at 1:37 PM The Assistant Director of Nursing (ADON) was summoned to the resident's room and was shown the placement of the resident's call pad.On 10/07/2025 at 1:39 PM A brief interview with the ADON was conducted. When asked what fall intervention measures should be in place for Resident #213, the ADON stated the fall mats, bed in low position and that the call pad should be on the right side of the bed because the resident falls on that side. The ADON confirmed that the call pad was neither near reach nor on the right side of the resident's bed. She acknowledged that the care plan interventions indicated to prevent future falls were not all in place. The ADON was notified that this will be a concern.On 10/07/2025 at 2:10 PM The administrator and the Director of Nursing (DON) were made aware of the concerns regarding fall prevention interventions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interviews, it was determined that the facility failed to maintain accurate resident records. This was evident for 1 (Resident #202) out of 18 residents reviewed during the complaint survey. The findings include: On 10/7/2025 at 9:09 AM, A review of Complaint #2561490 was conducted. The complainant alleged that Resident #202 was not being cleaned after incontinent episodes. On 10/7/2025 at 9:52 AM, A review of Resident #202's medical record was conducted. A review of the Documentation Survey Report for the month of June indicated that the resident had bladder and bowel incontinent episodes on 6/8/2025, 6/25/2025, and 6/27/2025 during the night shift but the Geriatric Nursing Assistant (GNA) documentation noted Not Applicable (NA) for the Toileting Hygiene task during the night shift. On 10/07/2025 at 10:47 AM, an interview with the Director of Nursing was conducted. When asked what the expectation was for GNA documentation in regard to toileting hygiene? The GNA's should document if care was provided and document any refusals. The GNA documentation found for Resident #202 in the month of June 2025 was presented to the DON. When asked what documenting NA in the Toileting Hygiene task signified, the DON stated the GNA was probably trying to document that the resident refused because the resident had refusing behaviors. When asked if it was the expectation that that staff document Resident Refused (RR) for resident refused rather than NA, The DON stated that if the GNAs have the option to document RR in the chart then they should document it as refused. On 10/7/2025 at 11:48 AM, GNA #18 was interviewed. When asked what the documentation of NA under Toileting Hygiene indicated, the GNA stated that if the care or task does not apply to the resident they will document NA. When asked for the specific case where the GNA documented NA for Resident #202 in Toileting Hygiene and the resident had incontinent episodes, the GNA stated that they meant to document RR but were unable to so they documented NA.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of complaints, observations and interviews, it was determined that the facility failed to have a fully functioning call bell system. This was evidenced by the lack of an audible call bell system on the second floor and had the potential of affecting all residents.The findings include:Tracheostomy is a surgical procedure that creates an opening in the trachea (windpipe) and inserts a tube to help a person breatheOn 10/07/2025 at 9:30 AM A review of complaint #328740 was conducted. The review revealed an allegation that stated call bells were not answered in a timely manner.On 10/07/2025 at 9:47 AM The surveyor observed that the call bell light was on outside room [ROOM NUMBER], which was located next to the nurses' station. No audible sound was heard in the hallways or at the nurse's station. Resident #216's door had a contact precaution sign on. At 9:58 AM, the Surveyor was gowning to enter the resident's room when Staff #11 told the surveyor that S/He had just changed the resident and that the resident needed help with the phone, which Staff #11 was not able to assist with.On 10/07/2025 at 10:05 AM An interview with Resident # 216 was conducted. The resident reported that they had called for a nurse because they needed someone to suction their tracheostomy.When asked if the call bell response time was usually long, the resident reported yes and that in the past they had waited up to an hour before anyone responded to the call bell. On 10/07/2025 at 1:00 PM During another second-floor unit rounding, the surveyor observed that the call light sign was on outside room [ROOM NUMBER]. The surveyor went to the nurses' station where there were 3 staff members talking. While standing at the nurses' station, the surveyor showed the Assistant Director of Nursing (ADON) that the call light sign was on for room [ROOM NUMBER]. The surveyor then asked the ADON if she heard any audible call sound at the nurses' station or the hallways, the ADON replied no, that she did not hear any call bell sound. The surveyor notified the ADON that the call bell system was expected to have visual signal and the sound was supposed to be audible enough for staff to hear. The ADON stated that she would notify the maintenance director.0n 10/08/2025 2:10 PM The administrator provided the surveyor with a document that indicated the facility had placed a work order request to an external facility to repair the call bell system on the second floor.On 10/09/2025 at 9:59 AM An interview with the Maintenance Director was conducted. He reported that no one had reported that the call bell system had no audible sound. He acknowledged that the second-floor call bell system sound was significantly lower compared to the first floor. He also reported that this was a new problem because he had inspected the call bell system sound last month and had no issues then.On 10/09/2025 at 10:55 AM The Administrator was notified of the call bell system concerns.